MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-E)

CERTIFICATE OF DEATH

02147

Reg. Dist. No. 11336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 years

Hospital, institution, or street address where death occurred: -------- 202 Chestnut Street

How long in hospital or institution? ---------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 202 Chestnut Street
(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3.(a) FULL NAME: Sallie Mary Adkins

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Nathias J. Adkins

6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): September 5, 1873

8. AGE:	Years	Months	Days	If less than one day
	71	5	22	..... hrs. ..... min.

9. Birthplace: Wicomico County, Maryland
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Home

FATHER
12. Name: Jacob Nichols
13. Birthplace: Wicomico, County, Maryland

MOTHER
14. Maiden name: Martha Cordy
15. Birthplace: Wicomico County, Maryland

16. Informant: Louis Adkins
Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2 1945 (month) (day) (year)

Cemetery or crematory: M.P.

Location: Delmar, Delaware

18. Funeral director: W. S. Bacon & Co

Address: Delmar, Delaware

19. 3/2 (Date rec'd by registrar) 1945 Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27th 1945, at 12 N. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1944, to Feb. 27 1945
and that I last saw her alive on Feb. 27 1945

	DURATION
Immediate cause of death: Coronary Embolism	24 hrs
Due to: Chronic Nephritis	6 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: .....
Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other

Address: Delmar, Del. Date signed: Feb 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33a

CERTIFICATE OF DEATH

62148

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Edna

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route #2.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Rufus Banks

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Aug 14 1943

8. AGE:

Years	Months	Days	If less than one day
1	6	2	...hrs. ...min.

9. Birthplace: Allen md (Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER

12. Name: Joseph Smith

13. Birthplace: Lynch Ky

MOTHER

14. Maiden name: Grace Banks

15. Birthplace: Allen md

16. Informant: Gladys Banks

Address: Allen md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19-45 (month) (day) (year)

Cemetery or crematory: Parsonsburg

Location: Allen md

18. Funeral director: James T. Stewart

Address: Salisbury Md

19. 2/19/45 (Date rec'd by registrar) Elizabeth E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1945, at 2 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 16 1945 and that I last saw him alive on Feb. 16 1945

Immediate cause of death	DURATION
Influenzal Meningitis	7 days
Due to: Influenzal Pneumonia	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Rivers Hanson M.D. M. D. or other

Address: Salisbury, Md Date signed: 2/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02149

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Mardela.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Fannie H. Bennett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 30 1877

8. AGE: Years: 67 | Months: 9 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Wic Md (Town, county, and state)
10. Usual occupation: Farm work
11. Industry or business
FATHER 12. Name: Samuel H. Bennett
13. Birthplace: Md
MOTHER 14. Maiden name: Sallie E. Venables
15. Birthplace: Md
16. Informant: Charles H. Bennett
Address: Salisbury
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-13-45 (month) (day) (year)
Cemetery or crematory: Mardela
Location: "
18. Funeral director: Graveyard Bros
Address: Sharptown
19. 2/13/45 19.. (Date rec'd by registrar) W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11 19 45 at unknown M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Accidental 19.. 19.. to date 19..
and that I last saw alive on 19..

Immediate cause of death: Pulmonary hemorrhage — DURATION: Sudden death
Due to: Probably Tuberculosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] Deputy Medical Examiner
M. D. or other
Address: Salisbury, Md Date signed 2/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1704)

02150

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Fruitland Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Samuel Brewer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Elsie Brewer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1896

8. AGE: Years	Months	Days	If less than one day
48	2	1	..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual occupation Sawmill Worker

11. Industry or business Lumber

FATHER 12. Name Samuel S. Brewer

FATHER 13. Birthplace Ohio

MOTHER 14. Maiden name Ida J. Lapham

MOTHER 15. Birthplace Ohio

16. Informant Mrs. Charles Gibbons

Address Fruitland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8, 1945 (month) (day) (year)

Cemetery or crematory Friendship Cemetery

Location East Princess Anne Md.

18. Funeral director Dale Pasfield

Address Princess Anne, Md.

19. 2/6 1945 Essie D. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 5 1945, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19.. and that I last saw ... alive on ..... 19..

Immediate cause of death	DURATION
Fractured skull	sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations NS

Date of op.

Autopsy results NS

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-5-45

Where did injury occur? Fruitland (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Truck struck by train Injured at work? No

23. SIGNATURE John Hopkins M.D. M. D. or other

Address Salisbury, Md. Date signed 2/5/45

STATE OF MARYLAND—CERTIFICATE OF DEATH 02151

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (33-2)

County Wicomico. Registration Dist. No. 332

Village or City Near Willards Md. No. St., Ward

(If death occurred in a hopital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurred 6 yrs. 6 mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Elijah Bunting. If U. S. Veteran, specify WAR —

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorcad HUSBAND of (or) WIFE of Nellie Bunting.

6. DATE OF BIRTH (month, day, and year) Feb. 15 1878

7. AGE	Yaars	Months	Days	If LESS then 1 day, hrs. or min.
	67	0	9	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farming

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. —

10. Date deceased last worked at this occupation (month and year) 1942

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) Worcester. (State or country) County.

FATHER

13. NAME James Bunting

14. BIRTHPLACE (city or town) Worcester (State or country) Co.

MOTHER

15. MAIDEN NAME Nancy Layton.

16. BIRTHPLACE (city or town) Worcester (State or country) Co.

17. INFORMANT Nellie Bunting (Address) Willards Md.

18. BURIAL, CREMATION, OR REMOVAL Place Burial Bittle Co. Date Feb. 27th, 1945

19. UNDERTAKER Wm. Howard Wells (Address) Pittsville Md.

20. FILED Feb. 27, 1945 Lillian R. Davis Registrar. Local

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Feb. (Month) 24 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attandad deceasad from Aug. 15, 1944 to Feb. 24, 1945

I last saw him alive on Feb. 24, 1945; daath is said to have occurred on the dete stated above, at 925 p. m.

Tha PRINCIPAL CAUSE OF DEATH and ralatad causes of importance ware as tollows:

	Date of onset
Carcinoma, primary of left hand and arm,	5 mos.
Became generalized, and	
metastasized to other parts.	

Other Contributory Causes of Importance:

Nama of operation — Date of —

What test confirmed diagnosis? — Was there an autopsy?

23. If daath was dua to external causas (VIOLENCE) fill in also tha following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceasad? No

If so, specify

(Signed) Frank R. Lewis M. D.

(Address) Willards, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own **home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93

02152

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Veneka
Hospital, institution, or street address where death occurred: ✓
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1704 East Main St.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Annie E. Causey

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: W. Bruce Causey
6.(c) If alive, give age ✓ years
7. Birth date of deceased (mo., day, yr.): April 17, 1877.

8. AGE: Years	Months	Days	If less than one day
67	10	3	hrs. min.

9. Birthplace: Wicomico Co., Md. (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business: ✓

FATHER
12. Name: Isaac Murray
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Elizabeth Bounds
15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. Howard L. Gaddy
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45. (month) (day) (year)
Cemetery or crematory: Parsons
Location: Salisbury, Md.

16. Funeral director: De Hill & Pleasanton Co.
Address: Salisbury, Md.

19. 2/17 (Date rec'd by registrar) 1945 — P. Woolford Walter, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 15, 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1944 to Feb 15 1945
and that I last saw her alive on Feb 1 1945

Immediate cause of death	DURATION
Acute pancreatitis	6 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Brownley M.D.
M. D. or other
Address: Salisbury Md Date signed Feb 16

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

02153

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Maryland Apt. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Snow Hill (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Emily L. Collins

3.(b) Social Security Number

English Spelling Salisbury, Md

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 - 1925

8. AGE:

Years	Months	Days	If less than one day
19	8	14	hrs. min.

9. Birthplace Snow Hill Worcester Md (Town, county, and state)

10. Usual occupation Waitress

11. Industry or business English Spelling

FATHER

12. Name Edward L. Collins

13. Birthplace Maryland

MOTHER

14. Maiden name Carrie Purnell

15. Birthplace Maryland

16. Informant Miss Carrie Collins

Address Snow Hill, Md

17. Burial, cremation, or removal. Which? Burial Date thereof Feb. 14 45 (month) (day) (year)

Cemetery or crematory Bath Methodist

Location Snow Hill Md

18. Funeral director Hearne Dynamite

Address Snow Hill, Md

19. 2/14 1945 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 12 1945 at 1 9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw ... alive on ... 19 ...

	DURATION
Immediate cause of death Burns of body & asphyxiation	sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2-12-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Hotel

Means of injury Fire in hotel Injured at work? No

23. SIGNATURE Jas Lankford MD Deputy Medical Examiner M. D. or other

Address Salisbury, Md Date signed 2/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

02154

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Mardela

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Andrew Lee Conway (Mr. James Conway)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Clementine Conway

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Nov. 26 - 1866

8. AGE: Years	Months	Days	If less than one day
78	2	20	...hrs. ...min.

9. Birthplace: Medford Mass.

(Town, county, and state)

10. Usual occupation: Merchant at

11. Industry or business: Fence station + Store

12. FATHER Name: William Conway

13. Birthplace: St. Johns (or Beaufinish) Canada

14. MOTHER Maiden name: Catherine Moore

15. Birthplace: Cork Ireland

16. Informant: Mrs. Anna Conway Carter

Address: 17 Front St. Cambridge Mass

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17-45 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Maryland

18. Funeral director: Hallowy & Co. Walter K. Hallowy

Address: Salisbury Maryland.

19. 2/17/45 (Date rec'd by registrar) Harriet E. Johnson (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 - 1945 at 11.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~1940~~ to Feb 16 1945 and that I last saw h... alive on Feb 16 1945

	DURATION
Immediate cause of death: Chronic Myocarditis	6 mos.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J.A. Rademaker MD

M. D. or other

Address: Salisbury Md. Date signed 2/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

02155

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sixteen years
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Rosa Cannish

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a a	Widow

6.(b) Name of husband or wife: William Cannish
Dead 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1838

8. AGE: Years	Months	Days	If less than one day
106	—	—	....hrs. ....min.

9. Birthplace: Pontilcake md (Town, county, and state)
10. Usual occupation: no
11. Industry or business: same as above

FATHER
12. Name: John Runnen
13. Birthplace: Pontilcake

MOTHER
14. Maiden name: Maria E. Elgy
15. Birthplace: Pontilcake Co md

16. Informant: Mrs Mary Roberts
Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 4-1945 (month) (day) (year)
Cemetery or crematory: Bibb Road
Location: Mt. Vernon md
18. Funeral director: James A. Stewart
Address: Salisbury Md

19. Feb 4 1945 Received by registrar
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1, 1945, at 6 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 20, 1944, to Feb. 1 1945
and that I last saw h er alive on Jan. 16, 1945

Immediate cause of death	DURATION
Due to: Acute Nephritis	3 wks.
Due to: Acute cystitis. Cured. Duration 3 weeks.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: G H Sembly M.D.
M. D. or other
Address: Salisbury Md Date signed: Feb 3 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110-a)

02156

CERTIFICATE OF DEATH

FILM No. G 9 4 MAY 14 1945

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Princess Anne Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mack Creasy

3.(b) Social Security Number

4. Sex: M | 5. Color or race: W | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Willie Creasy

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): April 28, 1889

8. AGE: Years: ~~54~~ 55 | Months: 9 | Days: 8 | If less than one day ... hrs. ... min.

9. Birthplace: Rogersville Tennessee (Town, county, and state)

10. Usual occupation: Sawmill Workman

11. Industry or business: Lumber

FATHER — 12. Name: Charles Creasy

13. Birthplace: Rogersville Tennessee

MOTHER — 14. Maiden name: Sarah Kleeper

15. Birthplace: Rogersville Tennessee

16. Informant: Mrs Willie Creasy

Address: Princess Anne Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8 1945 (month) (day) (year)

Cemetery or crematory: Highland Cemetery

Location: Rogersville, Tennessee

18. Funeral director: Dale Dashiell

Address: Princess Anne Md

19. 2/6 1945 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 5 1945, at 8 9 M

21. I CERTIFY that death occurred on the date above stated; that I ~~attended deceased from~~ 19 ... 19 ... and that I ~~last saw~~ ... alive ... 19 — medical examiner of post

Immediate cause of death: Fractured skull — DURATION: rapidly death

Due to:

Due to:

Other conditions: Fractured left arm, " Rt arm (Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident. Date of 2/5/45

Where did injury occur? Fruitland Wicomico Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Highway & RR track

Means of injury: Truck struck by RR. Injured at work? no

23. SIGNATURE: [illegible] Deputy Med Examiner M.D. or other

Address: Salisbury, Md. Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Hanson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

02157

CERTIFICATE OF DEATH

Reg. Diat. No. 333

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, institution, or street address where death occurred: P.S. Bowyer,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 215 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Grace Allen Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Joseph H. Davis
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Jan. 31- 1896

8. AGE: Years	Months	Days	If less than one day
49	—	8	....hrs. ....min.

9. Birthplace: Tyaskin Maryland (Town, county, and state)
10. Usual occupation: Home m/e
11. Industry or business: at Home

FATHER
12. Name: William F. Denton
13. Birthplace: Tyaskin Maryland

MOTHER
14. Maiden name: Mae Covington
15. Birthplace: Baltimore Maryland

16. Informant: Mr Joseph H. Davis
Address: 215 Washington St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11-45 (month) (day) (year)
Cemetery or crematory: Tyaskin M. Church Cem
Location: Tyaskin Maryland

18. Funeral director: Holloway & Miller & Holloway
Address: Salisbury Maryland.

19. 2/11/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8 45 at 9. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/2 19 45 to 2/8 19 45
and that I last saw h.. alive on 2/8 19 45

Immediate cause of death	DURATION
Coronary occlusion	Immediate
Due to Hypertensive Cardio-vascular Renal disease	6 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. Rivers Hanson M.D.
M. D. or other
Address: Salisbury, Md Date signed 2/9/45

Dr. Brown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02158

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred: 303 Hazel Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 303 Hazel Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John Leeman Davis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sula K. Davis

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Jan. 29-1882

8. AGE:

Years	Months	Days	If less than one day
63	0	15	... hrs. ... min.

9. Birthplace: Salisbury Md. (Town, county, and state)
10. Usual occupation: Shipping Clerk at Bakery
11. Industry or business:

FATHER
12. Name: Joseph Davis
13. Birthplace: Berlin Md.

MOTHER
14. Maiden name: Maggie Leeman
15. Birthplace: Salisbury Md.

16. Informant: Mrs. Sula K. Davis
Address: 303 Hazel ave. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb 16 (month) (day) 1945 (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland
18. Funeral director: Hollowy & C. Walter R. Holloway
Address: Salisbury Maryland.

19. 2/16 1945 Received by Registrar: Harriet E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1945 at 4.37 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 14 1945.
and that I last saw him alive on 2/14 1945

Immediate cause of death	DURATION
Valvular heart disease	6 mos
Due to: Lobar Pneumonia	10 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles F. Brown M.D.
M. D. or other
Address: Salisbury Md. Date signed: 2/15/45

M

VS A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02159

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) Rural

How long in above place of death? 3 yrs 18 days

Hospital, institution, or street address where death occurred:

E.S. Md Sanatorium

How long in hospital or institution? 3 yrs 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Marydel (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Filomena Densa

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

B.(b) Name of husband or wife: none

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 3, 1924

8. AGE: Years	Months	Days	If less than one day
20	10	29	hrs. min.

9. Birthplace: Philadelphia (Town, county, and state) Pa.

10. Usual occupation: none

11. Industry or business: —

MOTHER 12. Name: Joseph Densa

FATHER 13. Birthplace: Spain

MOTHER 14. Maiden name: Violet Richard

15. Birthplace: England

16. Informant: deceased on admission

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5. 1945. (month) (day) (year)

Cemetery or crematory: Greenabaro

Location: Greenabaro Md

18. Funeral director: Raymond B. Rawlings

Address: Greenabaro Md

19. 2/6 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 19 45, at 6.45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/14/42 19 to 2/2/45 19 and that I last saw her alive on 2/1/45 19

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 5 yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Owen, M.D. M. D. or other

Address: Salisbury Md Date signed: 2/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

02160

Reg. Diat. No. 333

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution? 14 hrs. 45 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route #1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: DISHAROON, MR. DEWEY JACKSON.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	White	widowed

6.(b) Name of husband or wife: Florence Downs Disharoon
6.(c) If alive, give age: dead years

7. Birth date of deceased (mo., day, yr.): January 9, 1898

8. AGE: Years 47 | Months 1 | Days 1 | If less than one day: hrs. min.

9. Birthplace: Wicomico, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Handsbury Disharoon
13. Birthplace: Whaleyville, Md.

MOTHER
14. Maiden name: Kate Truitt
15. Birthplace: Wicomico County Md.

16. Informant: Mrs. Kate Disharoon
Address: Berlin, Route #1, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/45 (month) (day) (year)
Cemetery or crematory: Truitt Cemetery
Location: Willards, Md.

18. Funeral director: M. Pasha Watson
Address: Salisbury, Md.

19. 2/10/45 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1945, at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9 1945 to Feb 10 1945 and that I last saw h... alive on Feb 10 1945

	DURATION
Immediate cause of death: Coronary Thrombosis.	2 days.
Due to: Chronic myocarditis	1 year.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. A. Rademaker M.D.
M. D. or other
Address: Salisbury, Md. Date signed: 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

02161

CERTIFICATE OF DEATH

Reg. Diet. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: White Haven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 15 years

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: White Haven

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Page T. Dorsey

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	widowed

6.(b) Name of husband or wife: Don't know

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): about 1863

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 82	—	—		

9. Birthplace: Spotsylvania Co. Virginia (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Same

FATHER

12. Name: Don't know

13. Birthplace: Don't know

MOTHER

14. Maiden name: Don't know

15. Birthplace: Don't know

16. Informant: Alfred White

Address: 809 Carey St, Baltimore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-27-45 (month) (day) (year)

Cemetery or crematory: White Haven Cemetery

Location: White Haven, Maryland

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury, Md.

19. 2/27 (Date rec'd by registrar) 1945 P. Woolford Nelle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945, at 12 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1944 to — 1945 and that I last saw him alive on June 13 1944

Immediate cause of death	DURATION
Chronic myocarditis	2-3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brammer M. D. (M. D. or other)

Address: Salisbury, Md. Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. To physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr. Mock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02162

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Vienna

County: Salisbury

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: P. B. Hoyt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For nonresidents give residence of mother) Wrc.

State: Md. County: Worcester

City or town: Eden (If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: James Otis Dykes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 13 1932

8. AGE: Years: 12 | Months: 8 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: R.D. #1 Fruitland Md. (Town, county, and state)

10. Usual occupation: School Boy

11. Industry or business:

FATHER — 12. Name: Curtis Thomas Dykes

13. Birthplace: R.D. Fruitland Md

MOTHER — 14. Maiden name: Emma Elizabeth McNutt

15. Birthplace: Somerset Co. Md

16. Informant: Curtis T. Dykes

Address: R.D. #1. Eden Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13-45 (month) (day) (year)

Cemetery or crematory: Christ Cemetery

Location: Worcester Co. Md

18. Funeral director: Holloway & G. Walter R. Holloway

Address: Salisbury Md.

19. 2/13/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 11 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 9 1945, to Feb 11 1945

and that I last saw h— alive on Feb 11 1945

Immediate cause of death	DURATION
Acute Cerebellitis	
Due to: Bronchitis	Hrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Lumbar puncture

Date of op. 2/11/1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Salisbury Md Date signed: 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

02163

CERTIFICATE OF DEATH

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 years
Hospital, Institution, or street address where death occurred: P. H. Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 106 High St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Edith Bell Edgecumbe

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Laurence Edgecumbe
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 17, 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	1	13		

9. Birthplace: Salisbury, Wicomico co. Md (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business:

FATHER
12. Name: L. D. Bell
13. Birthplace: Wicomico co. Md

MOTHER
14. Maiden name: Elizabeth H Lumby
15. Birthplace: Worcester co. Md

16. Informant: H. Charles F. Bell
Address: Shreveport, La.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/6/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co
Address: Salisbury Md.

19. 2/6, 1945 (Date rec'd by registrar) Harriet L. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4, 1945 at 9 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945 to Feb 4 1945
and that I last saw h[illegible] alive on Feb 4 1945

Immediate cause of death	DURATION
Chron Myocarditis	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J Brewer M.D.
M. D. or other
Address: Salisbury Md. Date signed 2/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Brown

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02164

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, Institution, or street address where death occurred: R.D. #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lillie May Elliott

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William H. Elliott
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Dec. 27 th 1872

8. AGE: Years 72 | Months 1 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace R.D. #3 Salisbury Md.
(Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business at Home

FATHER
12. Name Thomas Beauty
13. Birthplace R.D. #3 Salisbury Md.

MOTHER
14. Maiden name Sarah Annie Hammond
15. Birthplace R.D. #3 Salisbury Md.

16. Informant Mr. Jerome Beauty
Address E. William St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14-45 (month) (day) (year)
Cemetery or crematory Bethel Cem.
Location Salisbury Maryland

18. Funeral director Fillmore & Co.
Address Salisbury Md.

19. 2/14 1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 4 1945, at 12.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7 1945, to 2/11 1945
and that I last saw h... alive on 2/11/1945

Immediate cause of death Pneumonia
Due to Carditis Rheumatic
Due to
Other conditions

(Include pregnancy within 3 months of death)

DURATION	
V days	
V yrs.	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Charles N. Brown M.D.
M. D. or other
Address Salisbury Md. Date signed 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

02165

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, institution, or street address (if not at home) where death occurred: 800. E. Church St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(Ex: newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 800. E. Church St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Henry Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella May Evans
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): May 4 - 1872

8. AGE: Years 72 | Months | Days | If less than one day: hrs. min.

9. Birthplace: R.D. Georgetown Del.
(Town, county and state)

10. Usual occupation: Retired

11. Industry or business: Dealer in Produce

FATHER
12. Name: Isaac Willett Evans
13. Birthplace: Sussex Co. Del.

MOTHER
14. Maiden name: Nancy Miller
15. Birthplace: Sussex Co. Del.

16. Informant: Mrs. Ella M. Evans
Address: 800. E. Church St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 5 45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 2/6 19 46 (Date rec'd by registrar) Bessie T. L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3 45 at 12.30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive on ... 19 ...

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to: Chronic Myocarditis	6 mos
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury injured at work?

23. SIGNATURE: L.A. Rademaker M.D. Deputy Medical Examiner
M. D. or other
Address: Salisbury Md. Date signed: 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64)

02166

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Peninsula General Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: P.O. Delmar RFD#3 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: RFD # 3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: ---

3. (a) FULL NAME: Raymond William Foskey

3. (b) Social Security Number: 719-14-1573

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Elsie Jones Foskey
6(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): Sept. 19, 1921

8. AGE: Years	Months	Days	If less than one day
23			____hrs. ____min.

9. Birthplace: Delmar, Delaware (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm

FATHER
12. Name: John R.Foskey
13. Birthplace: Wicomico County, Md.

MOTHER
14. Maiden name: Lulu Plmummer
15. Birthplace: Laurel, Delaware

16. Informant: John R.Foskey
Address: Delmar, Del. RFD # 3

17. Burial (Burial, Cremation, or Removal): Date thereof: Feb, 14th-45 (month) (day) (year)
Cemetery or Crematory: Smith Mills
Location: Delmar, Del. RFD

18. Funeral director: H. S. Mann Co
Address: Delmar, Delaware

19. 2/14, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 th. 1945, at 4 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to ---, and that I last saw deceased alive on --- 1945

Immediate cause of death	DURATION
Gunshot wound of chest	2/14/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of: 2/14/45
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?): Farm
Means of injury: shot himself with shotgun Injured at work? No

23. SIGNATURE: [illegible] deputy med. ex. M. D. or other
Address: Salisbury, Md. Date signed: 2/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

02167

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred: Masonic Home Hotel Salisbury Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: Accomac

City or town: Onancock
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Josephine Nock Fosque

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: John M Fosque

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 4 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	5	8		

9. Birthplace: Mapp's Accomac Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Nesmith Wallop Nock

13. Birthplace: Mappsville, Virginia

MOTHER — 14. Maiden name: Emily Byrd

15. Birthplace: Hallwood, Virginia

16. Informant: Mrs. Audrey Esham

Address: Berlin, Maryland

17. Burial, cremation, or removal. Which?: Burial Date thereof: 2/14/45 (month) (day) (year)

Cemetery or crematory: Onancock Cemetery

Location: Onancock, Va.

18. Funeral director: Burbage-Johnson

Address: Onancock Va.

19. 2/14 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12, 1945 at 1-4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw ... alive on ... 19...

Immediate cause of death	DURATION
Burns of body	Sudden
Conflagration	death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 2/12/45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Hotel

Means of injury: Fire in hotel Injured at work? No

23. SIGNATURE: H. Rademaker MD Deputy Medical Examiner
M. D. or other

Address: Salisbury Md Date signed: 2/12/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

Dr. Gray 0-7168

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico Co

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Months

Hospital, Institution, or street address where death occurred:
105 Cherry St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lula E. Gillis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widow

6.(b) Name of husband or wife: Henry Gillis

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): October 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	3	27	hrs. min.

9. Birthplace: Mt. Vernon, Somerset, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Edward Dashiell
13. Birthplace: Mt. Vernon, Md.

MOTHER
14. Maiden name: Ellen Bayley
15. Birthplace: Dorchester County, Md.

16. Informant: Clifford Gillis

Address: Hebron Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)

Cemetery or crematory: Mardela Cemetery

Location: Mardela Md.

18. Funeral director: Mrs. C. B. Messick & Sons

Address: Hebron Md.

19. 2/16 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1945 at 6:40 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 14 1945 to Feb. 14 1945

and that I last saw h— alive on Feb. 14 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardio-renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Salisbury Md. Date signed Feb 16, 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Insley

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

02169

Reg. Dist. No. 353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred: 2004 N. Division St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2004 N. Division St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Alice May Hastings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas N. Hastings
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): May 15-1872

8. AGE:

Years	Months	Days	If less than one day
72	8	20	... hrs. ... min.

9. Birthplace: Wicomico Co. Md.
(Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home
FATHER 12. Name: Samuel Foster
13. Birthplace: Wicomico Co. Md.
MOTHER 14. Maiden name: Martha Jane Culver
15. Birthplace: Wicomico Co. Md.
16. Informant: Samuel R. Hastings
Address: 1713 N. Division St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 2/7/1945 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5th 1945 at 2.a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1945 to only 1945
and that I last saw h.. alive on Feb. 4 1945

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury: ... Injured at work?

23. SIGNATURE: Henry A. Insley M. D. or other
Address: Salisbury Md. Date signed 2/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (115-E)

02170

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 116 Fooks Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 116 Fooks
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ida Belle Hastings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Ernest Franklin Hastings
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): April 17, 1879

8. AGE:

Years	Months	Days	If less than one day
65	10	9	hrs. min.

9. Birthplace: Salisbury Maryland
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: John Edward Hastings
13. Birthplace: Salisbury Maryland

MOTHER
14. Maiden name: Mary Ellen Wilson
15. Birthplace: Salisbury Maryland

16. Informant: Mr. Ernest H. Hastings
Address: 116 Fooks St. Salisbury Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb 28 45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Maryland

19. 2/27 1945 Received by registrar: Lawrence E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26 1945 at 7:47 A.M.

I CERTIFY that death occurred on the date above stated; that I attended deceased from 25-2-45 19.. to 26-2-45 19.. and that I last saw h.. alive on 26-2-45 19..

Immediate cause of death	DURATION
Streptococcal Sepsis	24 hrs
Due to: Streptococcal throat infection	
Due to:	
Due to:	
Other conditions: Heart Failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Carrie L. Hearn M.D. M. D. or other
Address: 203 W. Church St. Date signed: 27-2-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

CERTIFICATE OF DEATH

02171

Reg. Diat. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 mo. 17 da

Hospital, institution or street address where death occurred: P.B. Hoyt.

How long in hospital or institution? 27½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Parsons Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Betty Jane Hitchens

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 17-1944

8. AGE: Years	Months	Days	If less than one day
[redacted]	6	18	hrs. min.

9. Birthplace: P.B. Hoyt. Salisbury Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: James H. Hitchens

13. Birthplace: Salisbury Md.

MOTHER — 14. Maiden name: Irene Bennett

15. Birthplace: Hebron Md

16. Informant: Mr. James H. Hitchens

Address: Parsons Road Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 6-45 (month) (day) (year)

Cemetery or crematory: Hebron Cem.

Location: Hebron Maryland

18. Funeral director: Hollowell & Walter R. Hollowell

Address: Salisbury Md.

19. 2/6/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1945, at 10-55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1945, to Feb 4 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
(a) Pneumonia	4 days
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Wanner M.D. M. D. or other

Address: Salisbury Md. Date signed: 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Daisy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

02172

Reg. Diat. No. 339

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 years
Hospital, Institution, or street address where death occurred: 712 Pearl St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 712 Pearl St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Georgeanna Hitchens

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife William Hitchens
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Jan. 1 - 1870

8. AGE: Years	Months	Days	If less than one day
75	1	9	hrs. min.

9. Birthplace R.D. Town Hill Md.
(Town, county, and state)
10. Usual occupation Home mf
11. Industry or business at Home

FATHER
12. Name Ebenezer Gray
13. Birthplace Md.

MOTHER
14. Maiden name Martha Graham
15. Birthplace Md.

16. Informant Mrs. Nancy Gillis Matthews
Address 712 Pearl St. Salisbury Md

17. Burial Date thereof Feb. 13 / 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Parsons Cemetery
Location Salisbury Md
18. Funeral director Holloway & Walter P. Holloway
Address Salisbury Maryland

19. 2/13/1945 Harriet E. Johnson
(Date rec'd by registrar) Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10 1945, at 7 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1945, to Feb. 10 1945
and that I last saw h... alive on Feb. 10 1945

	DURATION
Immediate cause of death C.H. Valv Heart.	6 mos.
Due to C.H. Int - Nephritis	4 yrs.
Due to Arter Sclero.	5 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W O Daisy M.D.
M. D. or other
Address Salisbury Md Date signed 2/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

02173

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin

(If outside city or town limits, write RURAL and give nearest town)

Street No. BRANCH

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME E.

Mr. James Holland

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife: Mrs. Edna Holland

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): March 14 1883

8. AGE: Years: 61 | Months: 11 | Days: 0 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Berlin Worcester Co. Md.

(Town, county, and state)

10. Usual occupation: Carpenter.

11. Industry or business

FATHER

12. Name: Charles Holland

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Ennis.

15. Birthplace: Maryland.

16. Informant: Mrs. Robley Holland

Address: Berlin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)

Cemetery or crematory: Evergreen

Location: Berlin Md.

18. Funeral director: Franklin B. Heed.

Address: Salisbury Md.

19. 2/14 1945 (Date rec'd by registrar) Harold E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1945 at 11.55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1945 to Feb 14 1945 and that I last saw h... (M...) alive on 2-14 1945

	DURATION
Immediate cause of death: Uremia	4 weeks.
Due to:	
Due to:	
Other conditions: Hypertrophied Prostate	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertrophied Prostate

Date of op. Jan. 25, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No.

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J.O. Rademaker. MD

M. D. or other

Address: Salisbury Md Date signed 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

02174
Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Marie Fitchett Hughes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Hughes
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1886

8. AGE:

Years	Months	Days	If less than one day
58	3	4	hrs. min.

9. Birthplace: Selbyville, Del. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: William E. Fitchett
13. Birthplace: Selbyville, Del.
MOTHER 14. Maiden name: Estelfina Lyons
15. Birthplace: Selbyville, Del.
16. Informant: Wm. O. Fitchett
Address: 6725 Germantown Ave, Phila, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/3/45 (month) (day) (year)
Cemetery or crematory: Hebron Cem.
Location: Hebron, Md.
18. Funeral director: Mac C. Messick & Sons
Address: Hebron Md.
19. 3/1, 1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 27, 1945; at 6 55 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19.. to ... 19..
and that I last saw h... alive on ... at ... 19..

Immediate cause of death	DURATION
Fractured left hip	9 days
Due to	
Due to	
Other conditions: Chronic Myocarditis	1 year

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 2-16-45
Where did injury occur? Hebron (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury: fall on ice Injured at work? No
23. SIGNATURE: for Coroner Wicomico Co. Deputy Asst. Examiner M. D. or other
Address: Salisbury, Md Date signed 2/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02175

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred: 312 South Division St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 312 South Division St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Georgia Smith Huston

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Geo. T. Huston
6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): July 10 1870

8. AGE:

Years	Months	Days	If less than one day
74	7	11	...hrs. ...min.

9. Birthplace: Salisbury, Wicomico, Md
(Town, county, and state)
10. Usual occupation: At Home
11. Industry or business:
FATHER 12. Name: George W. Smith
13. Birthplace: Salisbury, Md
MOTHER 14. Maiden name: Sarah Anne Shockley
15. Birthplace: Wicomico Co Md
16. Informant: Reginald Huston
Address: Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/23/45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md
18. Funeral director: The Hill & Johnson Co
Address: Salisbury Md
19. 2/23, 1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21, 1945 at 9.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19.. to Feb 21 1945
and that I last saw h.. alive on Feb 21 1945
Immediate cause of death: Cerebral hemorrhage — DURATION: 1 yr
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: Salisbury Md Date signed: Feb 23

Dr. Daisy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02176

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred: 100 Patterson ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 Patterson ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nora Lee Johnson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Living Thomas Johnson
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): April 16 1888

8. AGE: Years	Months	Days	If less than one day
56	9	20	..... hrs. ..... min.

9. Birthplace: R.D. Princess Anne Md.
(Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: at Home
FATHER 12. Name: Sidney C. Dryden
13. Birthplace: R.D. Pocomoke Md.
MOTHER 14. Maiden name: Sallie Buttingham
15. Birthplace: R.D. Accomack Md.
16. Informant: Mr. Living T. Johnson
Address: 100 Patterson ave. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 9- 1945 (month) (day) (year)
Cemetery or crematory: Pusey Farm Cem
Location: Near Friendship Church West P.O. Dennis Md.
18. Funeral director: Holloway & Walton R. Holloway
Address: Salisbury Maryland.
19. 2/9/ 1945 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6th 1945, at 6.40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 1945, to Feb. 6 1945
and that I last saw h.. alive on Feb. 6 1945

Immediate cause of death	DURATION
Lobar Pneumonia	8 dys
Due to: Bronchitis	7 dys
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?
23. SIGNATURE: W O Lang M D
M. D. or other
Address: Salisbury Md. Date signed 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

02177

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Fruitland Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Princess Anne Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME W. Harvey Johnson

3.(b) Social Security Number 221-12-1131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Viola Johnson

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) August 6, 1906

8. AGE: Years	Months	Days	If less than one day
38	5	26	hrs. min.

9. Birthplace Princess Anne Md.
(Town, county, and state)

10. Usual occupation Lumberman

11. Industry or business Sawmill

FATHER 12. Name Irving Johnson

13. Birthplace Princess Anne Md.

MOTHER 14. Maiden name Mary Revell

15. Birthplace Princess Anne Md.

16. Informant Mrs. Viola Johnson

Address Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1945 (month) (day) (year)

Cemetery or crematory Episcopal Cemetery

Location Princess Anne Md

18. Funeral director Dale Washell

Address Princess Anne, Md.

19. 2/6/45 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5 19 45 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from died 19 to 19
and that I last saw [illegible] alive on 2-5-45 19

Immediate cause of death	DURATION
Fractured Skull	sudden death
Due to	
Due to	
Other conditions Fractured Rt arm.	

(Include pregnancy within 3 months of death)

Major findings of operations No

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2/5/45

Where did injury occur? Fruitland Wicomico Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway & Depot

Means of injury Train struck truck Injured at work? No?

23. SIGNATURE J. A. Parkinson MD Deputy Medical Examiner
M. D. or other

Address Salisbury Md. Date signed 2/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02178

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1101 W Maine St
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Henry Jones

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a. b.	Widower

6.(b) Name of husband or wife: Octavia Jones

6.(c) If alive, give age: dead yrs

7. Birth date of deceased (mo., day, yr.): about 1870

8. AGE:

Years	Months	Days	If less than one day
about 75	—	—	...hrs. ...min.

9. Birthplace: Salisbury Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER
12. Name: Jacob Jones
13. Birthplace: Salisbury md

MOTHER
14. Maiden name: Sallie Fitch
15. Birthplace: Salisbury md

16. Informant: Mrs Martha Purnell

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 3 1945
(month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury md

18. Funeral director: Jarvis P. Stewart

Address: Salisbury Md

19. 3/6 1945 Laura E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-28 1945 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-19 1945, to 2-28 1945
and that I last saw him alive on 2-25 1945

Immediate cause of death	DURATION
Congestive Heart failure	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ...Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: L A Purnell M. D. or other

Address: 200 W Main St. Date signed 2-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AT5

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0217:1

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 529 S. Division St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Franklin Kelly

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22-1943

8. AGE: Years: 1 | Months: 8 | Days: 6 | If less than one day: hrs. min.

9. Birthplace: P.G. Hospt. Salisbury Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Clarence Philmore Kelly

13. Birthplace: Wilmington, Del.

MOTHER — 14. Maiden name: Mary Louise Ogden

15. Birthplace: Salisbury Md

16. Informant: Clarence P. Kelly

Address: 529 S. Div. St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. (month) 1945 (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland

19. 3/1/45 (Date rec'd by registrar) Harriet E. Thomas (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 28 1945, at 3a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/27 1945 to 2/28 1945

and that I last saw him alive on 2/28 1945

Immediate cause of death	DURATION
Acute Fulminating Septicemia	1 day
Due to: Cardiac Thrombosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.

Autopsy results: Cardiac Thrombosis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Elmer A Hauson M.D. M. D. or other

Address: Salisbury Md Date signed: 3/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

02189

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: White Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Henry Larmore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Sigrid N. Larmore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1854

8. AGE:

Years	Months	Days	If less than one day
90	11	28	..... hrs. ..... min.

9. Birthplace: Tyaskin Wicomico Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER
12. Name: James Lasmore
13. Birthplace: Tyaskin Md.

MOTHER
14. Maiden name: Mckenzie
15. Birthplace

16. Informant: Mrs. Woodland Anderson
Address: White Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/45 (month) (day) (year)

Cemetery or crematory: Nanticoke Cemetery

Location: Nanticoke, Md.

18. Funeral director: Mrs. C. Merrick Davis

Address: Hebron, Md.

19. Feb 13 1945 (Date rec'd by registrar) R. Woolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11, 1945 at 5:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945 to Feb 11 1945 and that I last saw h[illegible] alive on Feb 11, 45 1945

Immediate cause of death	DURATION
Lobar Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: D. Allen Seild M.D. or other

Address: Nanticoke Md. Date signed 2-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

02181

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula Gen Hospital
How long in hospital or institution? 36 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Zion Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Long, Baby Girl

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 2-1945

8. AGE: Years: 0 | Months: 0 | Days: 0 | If less than one day: ____ hrs. 36 min.

9. Birthplace: Salisbury Wico, Md.
(Town, county and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: Frank Long
13. Birthplace: Blanker Md

MOTHER
14. Maiden name: Anna V. Littleton
15. Birthplace: Parksley Va.

16. Informant: Mr. Frank Long
Address: RD #3 Zion Road Salisbury Md

17. Buried (Burial, cremation, or removal? Which?) Date thereof: Feb. 3-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 2/13/1945 (Date rec'd by registrar) Carrie L. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1945 at 3:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____
and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Due to: Premature	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury Injured at work?

23. SIGNATURE: Philip A Insley M. D. or other
Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-a)

CERTIFICATE OF DEATH

02182

Reg. Dist. No. 999

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? On and [illegible]

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: somerset

City or town: Princess anne (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Miles, Otho

3.(b) Social Security Number 221-12-6315

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C.	

6.(b) Name of husband or wife: Bettie V. Miles

6.(c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Jan 22-1901

8. AGE:

Years	Months	Days	If less than one day
44	0	14	hrs. min.

9. Birthplace: Princess anne somerset co md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Richard Miles

FATHER 13. Birthplace: Princess anne somerset co Md

MOTHER 14. Maiden name: Ellen Milbourn

MOTHER 15. Birthplace: Princess anne somerset co Md

16. Informant: Arthur Miles

Address: Princess anne md

17. burial (Burial, cremation, or removal. Which?) Date thereof Feb 11-1945 (month) (day) (year)

Cemetery or crematory: Oakville Cemetery

Location: Princess anne md

18. Funeral director: Lukas & Woard

Address: marion sta md

19. 2/11 (Date rec'd by registrar) 19 45 Bessie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-5-45 at 8 91 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 19 to [illegible] 19

and that I last saw [illegible] alive on [illegible] 19

Immediate cause of death	DURATION
Crushed Chest	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 2/5/45

Where did injury occur? Fruitland (City or town) wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) highway

Means of injury Train struck car Injured at work? No

23. SIGNATURE: [illegible] MD

Address: [illegible] Date signed 2/5/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37a)

02183

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Rehoboth Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No ✓

3. (a) FULL NAME: William Thomas Mumford

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Harriett A. Mumford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18 — 1861

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
83	4	17		

9. Birthplace: Middletree Worcester MD
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: "

MOTHER — 14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. Roy W. Palmer

Address: Rehoboth Beach, Delaware

17. Burial (Burial, cremation, or removal which?) Date thereof: Feb. 7 '45 (month) (day) (year)

Cemetery or crematory: Baptist

Location: Middletree, MD

18. Funeral director: Pearse & Timmons

Address: Snow Hill, MD

19. 2/7/45 (Date rec'd by registrar) 19.46 Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5, 1945 at 6.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1, 1945, to Feb 5 1945 and that I last saw him alive on Feb 4, 1945

Immediate cause of death	DURATION
(a) Uremia	
Due to: (b) Hypertrophy, Prostate.	
Due to: (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: Henry A. Dukes M. D. or other

Address: ..... Date signed .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

02184

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 5 mo., 24d.
Hospital, Institution, or street address where death occurred:
Eastern Shore Tb San
How long in hospital or institution? 1 yr., 5 mo., 24 d

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Bishopville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rnral, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Welson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife Alfred Levin Welson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 31, 1881

8. AGE: Years	Months	Days	If less than one day
63	10	16	..... hrs. ..... min.

9. Birthplace Frankford Delaware
(Town, county, and state)
10. Usual occupation housework
11. Industry or business
FATHER 12. Name Asher F. Hudson
13. Birthplace Delaware
MOTHER 14. Maiden name Ida Haines
15. Birthplace Delaware
16. Informant deceased on admission
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20, 1945 (month) (day) (year)
Cemetery or crematory I.O.O.F.
Location Bishopville, Md.
18. Funeral director M. Parks Watson
Address Silbyville, Del.
19. 2/20/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 1945 at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/23/43 19.. to 2/17/45 19.. and that I last saw her alive on 2/17/45 19..

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please nnderline the canse to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Paul Ellis, M.D. or other
Address Salisbury Date signed 2/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Dairy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

02185

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs

Hospital, institution, or street address where death occurred: 205 W. Phila. Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 205 Phila Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Henretta Nichols

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Levin Thomas Nichols

6.(c) If wife, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 2nd 1861

8. AGE: Years: 83 | Months: 8 | Days: 9 | If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury Md. (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER — 12. Name: Samuel H. Perdue

13. Birthplace: Salisbury Md

MOTHER — 14. Maiden name: Elenora McAllister

15. Birthplace: Salisbury Md

16. Informant: Mrs. Ernest M. Nichols

Address: 205 W. Phila. Ave. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13-45 (month) (day) (year)

Cemetery or Crematory: Parsons Mem.

Location: Salisbury Md

18. Funeral Director: Fullmyer & Walter R. Holloway

Address: Salisbury Md.

19. 2/13/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 11th 1945 at 4 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 18 1940 to Feb 11 1945 and that I last saw h alive on Feb 11 1945

	DURATION
Immediate cause of death: Chr Valv Heart -	14yrs
Due to: Chr Lat Nephritis	1 yr
Due to: Auto Sclerosis	7 M
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W D Laynor M D

Address: Salisbury Md. M. D. or other

Date signed: 2/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No G 9 4 MAY 14 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02186

Reg. Dist. No. 333

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Edward Palmer

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1919

8. AGE: Years 25 | Months 10 | Days 14 | If less than one day hrs. min. 24

9. Birthplace Exmore, Va.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Fisher Palmer
13. Birthplace Exmore, Va.

MOTHER
14. Maiden name Lester Brown
15. Birthplace Exmore Va.

16. Informant Lester Palmer
Address Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)

Cemetery or crematory Parksley Cem.

Location Parksley, Md.

18. Funeral director Mrs. C. B. Messick & Sons

Address Pocomoke Md.

19. 2/16 (Date rec'd by registrar) 1945 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 10, 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death — DURATION

Coronary Thrombosis — Instantaneous

Due to — Death

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

None — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE [illegible] M. D. or other.

Address Salisbury, Md. Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-t

02187

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County Salisbury

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution or street address where death occurred: Peninsula Gen. Hospt.

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 414 Marshall St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joyce Ann Parker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 18 - 1933

8. AGE: Years 11 | Months 6 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Md. (town, county, and state)

10. Usual occupation School Girl

11. Industry or business

FATHER — 12. Name George Warren Parker

FATHER — 13. Birthplace Salisbury Md

MOTHER — 14. Maiden name Mary H. Mills

MOTHER — 15. Birthplace R.D. Quantico Md.

16. Informant Geo. Warren Parker

Address 414 Marshall St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 4 1943 (month) (day) (year)

Cemetery or crematory Wicomico Mem. Park

Location Salisbury Md

18. Funeral director Hellman & Walter R. Hollis

Address Salisbury Md.

19. 2/4/43 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2nd 1943 at 3:22 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 15 1943 to Feb 2 1943 and that I last saw h.r alive on Feb 1 1943

Immediate cause of death	DURATION
Rheumatic heart disease	2 yrs
Due to Scarlet fever	Dec 1942
Due to Chorea	June 1943
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Wanner M. D. M. D. or other

Address Salisbury Md Date signed 2/3/43

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1952)

CERTIFICATE OF DEATH

02188

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Stockton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) 70

2.(a) If veteran, name war

3.(a) FULL NAME George W. Parsons

3.(b) Social Security Number

Stockton Electric Ice + Power Co Stockton, Md

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife: Susie Parsons

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Nov. 22 - 1875

8. AGE:

Years	Months	Days	If less than one day
69	3	6	hrs. min.

9. Birthplace: Stockton Worcester Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Stockton Electric Ice + Power Co

FATHER 12. Name: John T. Parsons

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary Ed Jones

15. Birthplace: Maryland

16. Informant: Mrs Elmer F Parsons

Address: Stockton, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 2 45 (month) (day) (year)

Cemetery or crematory: Parksville

Location: Stockton, Md

18. Funeral director: Pearsall + Simpers

Address: Snow Hill, Md

19. 3/6, 1946 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 28 1945, at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Fractures hip	8 days
Due to: Cut of ice falling on him	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of Feb 28 45

Where did injury occur? Stockton (City or town) Worcester (County) Md (State)

Injured at home, farm, industry, public place (where?) Ice plant.

Means of injury: Cut of ice fell on him Injured at work? Yes.

23. SIGNATURE: John L. Riley Dep. Med Exam M. D. or other

Address: Snow Hill, Md Date signed 2/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02189

Reg. Diat. No. 332

1. PLACE OF DEATH
County Nicomico
City or town Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Nicomico
City or town Pittsville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Thomas Asbury Parsons

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna L. Parsons
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Aug. 9. 1881

8. AGE: Years	Months	Days	If less than one day
63	6	19	hrs. min.

9. Birthplace Pittsville Md.
(Town, county, and state)
10. Usual occupation retired
11. Industry or business Carpenter
FATHER 12. Name Thomas Asbury Parsons
13. Birthplace Pittsville Md.
MOTHER 14. Maiden name Julia Buckingham
15. Birthplace Pittsville Md.
16. Informant Mrs. Anna L. Parsons
Address Pittsville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 4-45 (month) (day) (year)
Cemetery or crematory Zion Church Cem.
Location Near Whitesville Del
18. Funeral director Holloway & Waller R. Holloway
Address Salisbury Maryland
19. Mar. 4 1945 (Date rec'd by registrar) Lillian R. Davis Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28th 1945 at 12.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 26 to Feb 28 1945
and that I last saw h alive on Last Illness 19
Immediate cause of death Coronary thrombosis — DURATION 4 Hrs
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

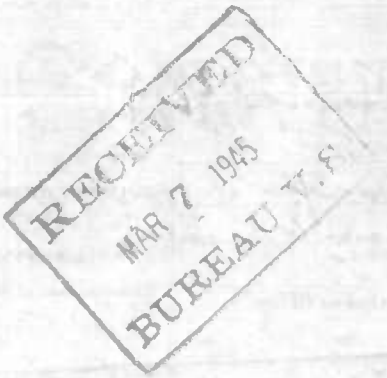
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank A. Lewis M.D.
M. D. or other
Address Willards, Md. Date signed 3/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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MAR 7 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

02199

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Near Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Peterson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	White	Widowed

B.(b) Name of husband or wife: Josephena Peterson

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): Jan 1 1856

8. AGE:

Years	Months	Days	If less than one day
89	1	2	...hrs. ...min.

9. Birthplace: Sweden (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Par Peterson
13. Birthplace: Sweden
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Josephena Peterson
Address: Mardela Md R.D.
17. Burial (Burial, cremation, or removal, which?) Date thereof: Feb 7-1945 (month) (day) (year)
Cemetery or crematory: Firemans
Location: Sharptown
18. Funeral director: Groves Bro's
Address: Sharptown
19. Feb 7- 1945 (Date rec'd by registrar) W H Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2 - 2 1945, at 2 - P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19..., and that I last saw deceased alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Sallie Lavender M.D. Deputy Medical Examiner
M. D. or other
Address: Salisbury, Md Date signed: 2/2/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-a

CERTIFICATE OF DEATH

02191

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 hours

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Rural, Westover
(If outside city or town limits, write RURAL and give nearest town)

Street No. # 7 R.F.D. 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Julius Pittman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Dorothy Lackey Pittman

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) March 9, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	6	hrs. min.

9. Birthplace Whitakers, Halifax, North Carolina
(Town, county, and state)

10. Usual occupation Saw Mill Laborer

11. Industry or business

FATHER
12. Name Julius Pittman, Sr.
13. Birthplace Whitakers, North Carolina

MOTHER
14. Maiden name Lillie Long
15. Birthplace Whitakers, North Carolina

16. Informant Mrs. Dorothy Pittman
Address Westover, Md. # 7 R.F.D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8 1945 (month) (day) (year)

Cemetery or crematory Christ M. E. Cemetery

Location Westover, Md. # 7 R.F.D. 1

18. Funeral director L. Harvey Bradshaw

Address Pocomoke City, Md.

19. 2/8/45 (Date rec'd by registrar) H. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 - 5 19 45, at 2 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-4 19 45 to 2-5 19 45

and that I last saw h alive on 2-5 19 45

Immediate cause of death	DURATION
Internal Injuries, Crushed Abdomen	6 hrs 45 min
Due to fractured Rt Leg	
Due to	
Due to	
Other conditions Lacerated Scalp, Lacerated Buttocks	None

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2/5/45

Where did injury occur? Frankland Wicomico Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway & RR Injured at work? No ?

Means of injury Truck struck by C[illegible]

23. SIGNATURE Joe Kaslowski M.D. Deputy Medical Examiner
M. D. or other

Address Salisbury, Md. Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02192

Reg. Diat. No. 389

1. PLACE OF DEATH:

County: Wicomico

City or town: Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Driving by in truck

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: RURAL, Westover

(If outside city or town limits, write RURAL and give nearest town)

Street No.: # RFD 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Pittman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Pauline Fing Pittman

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): December, --- 1900

8. AGE: Years	Months	Days	If less than one day
44	1	?	...hrs. ...min.

9. Birthplace: Whitakers-Halifax-North Carolina (Town, county, and state)

10. Usual occupation: Saw Mill Laborer

11. Industry or business

FATHER 12. Name: Julius Pittman, Sr.

13. Birthplace: Whitakers, North Carolina

MOTHER 14. Maiden name: Lillie Long

15. Birthplace: Whitakers, North Carolina

16. Informant: Mrs. Pauline Pittman

Address: Westover, Md. # RFD 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1945 (month) (day) (year)

Cemetery or crematory: Christ M. E. Cemetery

Location: Westover, Maryland # RFD 1

18. Funeral director: H. Harvey Bradshaw

Address: Pocomoke City, Md.

19. 2/8 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1945, at 8 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...1945, to ...1945

and that I last saw ...alive on ...1945

Immediate cause of death	DURATION
Fractured Skull	Sudden death
Due to	
Due to	
Other conditions: Fractured Rt Knee	11

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 2/5/45

Where did injury occur? Fruitland (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Railway & R/R

Means of injury: Train Injured at work? No ?

23. SIGNATURE: Deputy Med Examiner M. D. or other

Address: Salisbury Md Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02193

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred: P. G. Hospital
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Eden
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural 2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: David E. Pryor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Letha L. Pryor
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): April 11, 1892

8. AGE: Years	Months	Days	If less than one day
62	9	27	...hrs. ...min.

9. Birthplace: Wicomico Co. Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: David A. Pryor
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Charlotte Owens
15. Birthplace: Worcester Co. Md

16. Informant: Mrs. David E. Pryor
Address: Eden, Md. R. D. 2

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2/7/45
(month) (day) (year)
Cemetery or crematory: Wicomico Memorial Park
Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.
Address: Salisbury, Md.

19. 2/7 1945
(Date rec'd by registrar)
Harriet L. Johnson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1945 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 28 1945, to Feb. 4 1945
and that I last saw him alive on Feb. 4 1945

Immediate cause of death	DURATION
Lobar Pneumonia	8 days
Due to: Influenza Epidemic	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. L. Davis M. D.
M. D. or other
Address: Dublin Md. Date signed 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (185)

CERTIFICATE OF DEATH

02194

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 hrs

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Pocomoke city

(If outside city or town limits, write RURAL and give nearest town)

Street No. Cedar

(If rural, give LOCATION)

2.(a) If veteran, name war World War I

3.(a) FULL NAME Leslie Cleveland Redden

3.(b) Social Security Number 214-12-6488

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Married

6.(b) Name of husband or wife Elizabeth J. Redden

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) August 2, 1894

8. AGE: Years	Months	Days	If less than one day
50	6	5	...hrs. ...min.

9. Birthplace Pocomoke, Worcester, Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name John F. Redden

13. Birthplace md

MOTHER 14. Maiden name Mary Ellen Cuttew

15. Birthplace md

16. Informant Mrs. Elizabeth Redden

Address Pocomoke city, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 11, 1945 (month) (day) (year)

Cemetery or crematory Halls Hill

Location Pocomoke city R.F.D.

16. Funeral director Margarette H. Watson

Address Pocomoke city, Md.

19. 2/11 19 45 Received E.C. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-7 19 45 at 7 35 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19... to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Coronary Thrombosis	Died suddenly
Due to Anesthetic agent	
Due to Lacerated left Thumb	5 hrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Lacerated left thumb

Date of op. 2/7/45

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 2/7/45

Where did injury occur? Chincoteague (City or town) Accomac (County) Va (State)

Injured at home, farm, industry, public place (where?) Air base.

Means of injury Cut hand on saw Injured at work? Yes

23. SIGNATURE ...Deputy Medical Examiner U.S. M. D. or other

Address Salisbury Md Date signed 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

02195

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 years
Hospital, Institution, or street address where death occurred:
John B. Parsons Home
How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dock & Byrd Sts.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Anne Elizabeth Rider

3. (b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ✓
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1854.

8. AGE: Years: 90 | Months: 0 | Days: 11 | If less than one day: ... hrs. ... min.

9. Birthplace: Wicomico Co., Md.
(Town, county, and state)

10. Usual occupation: ✓

11. Industry or business

FATHER
12. Name: Noah Rider
13. Birthplace: Wicomico Co., Md.

MOTHER
14. Maiden name: Elizabeth Byrd
15. Birthplace: Wicomico Co., Md.

16. Informant: Mrs. B. Parsons Home.
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/3/45 (month) (day) (year)

Cemetery or crematory: Parsons
Location: Salisbury, Md.

18. Funeral director: Pete Hall & Johnson Co.
Address: Salisbury, Md.

19. 2/3 (Date rec'd by registrar) 1945 Harriet L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1, 1945, at 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1, 1945, to Feb 1, 1945 and that I last saw h[illegible] alive on Jan 1, 1945

Immediate cause of death	DURATION
Chr. Diff. Pneum.	7 days
Due to: Chr. Int. Nephritis	6 yrs
Due to: Hypertension	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ...
Means of injury: ... Injured at work?

23. SIGNATURE: W. D. Lang M.D. M. D. or other
Address: ... Date signed: 2/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

01. Dairy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02196

Reg. Dist. No. 3-33

1. PLACE OF DEATH.
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: R.D. #4.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED.
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #4.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME George Abraham Smith

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 24-1943
8. AGE: Years: 1 Months: 3 Days: 20 If less than one day: hrs. min.
9. Birthplace: R.D. #1. Salisbury Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Charles A. Smith
FATHER 13. Birthplace: Wicomico Co. Md.
MOTHER 14. Maiden name: Thelma Pusey
MOTHER 15. Birthplace: Somerset Co. Md
16. Informant: Mr. Charles A. Smith
Address: R.D. #4. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md
18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.
19. 2/17/45 (Date rec'd by Registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14th 1945, at 1.05 P M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 14 1945 to Feb. 14 1945
and that I last saw him alive on Feb. 14 1945

	DURATION
Immediate cause of death: Bronchial Pneumonia	3 days
Due to: Coryza	week
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?
23. SIGNATURE: H. O. Davis M.D. M. D. or other
Address: Date signed: 3/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170a

02197

CERTIFICATE OF DEATH

Reg. Dist. No. 323

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County Wicomico; City or town Fruitland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: P.R.R. Tracks

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Somerset

City or town Princess Anne (If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #2. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harold Francis Townsend

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Essie Louise Townsend

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): Sept. 3-1896

8. AGE: Years 48; Months 5; Days 2; If less than one day ... hrs. ... min.

9. Birthplace: Worcester Co. Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Logging steam saw mill

FATHER

12. Name: Ollie F. Townsend

13. Birthplace: Worcester Co. Md.

MOTHER

14. Maiden name: Ida Niblett

15. Birthplace: Worcester Co. Md.

16. Informant: Mrs. Essie Louise Townsend

Address: R.D. #2 Princess Anne Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 7-45 (month) (day) (year)

Cemetery or crematory: Perry Hawkin Church Cem.

Location: Somerset Co. Md.

18. Funeral director: Holloway Co. Walter R. Holloway

Address: Salisbury Md.

19. 2/7/ 19 45 Harriet E. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5th 19 45, at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... to ... 19 ... medical examiner's autopsy

and that I last saw h... alive on ... 19 ...

Immediate cause of death: Compound fracture of skull — DURATION: Sudden death

Due to

Due to

Other conditions: Compound fracture Rt. ankle (Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident — Date of: 2/5/45

Where did injury occur? Fruitland Wicomico Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): R.R. track

Means of injury: Train hit truck — Injured at work? No.

23. SIGNATURE: [illegible] M.D. Deputy Med. Examiner — M. D. or other

Address: Salisbury, Md. — Date signed: 2/5/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 108

02198

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 37 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Elijah Truitt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Louie Ann Truitt

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): November 20 1866

8. AGE:

Years	Months	Days	If less than one day
78	2	21	...hrs. ...min.

9. Birthplace: Fruitdale (Town) Wicomico (County) Maryland (State)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Wortley Truitt

13. Birthplace: Md.

MOTHER

14. Maiden name: Sallie Lewis

15. Birthplace: Md.

16. Informant: Mrs. Louie Truitt

Address: Willards, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 13 1945 (month) (day) (year)

Cemetery or crematory

Location: Willards, Md.

18. Funeral director: M. Pasha Watson

Address: Selbyville, Del.

19. 2/13 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10, 1945, at 8 45 A/P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 15 1944 to Feb. 10 1945

and that I last saw h.. alive on Feb. 10 1945

Immediate cause of death: Lobar Pneumonia — DURATION

Due to: Arteriosclerosis

Other conditions: Cardio Vascular Renal Disease

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Oliver S. Hanson M.D.

M. D. or other

Address: Salisbury, Md. Date signed 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

02199

Reg. Dist. No. 338

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 months

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. or R.F.D. Isabella
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Barbara Tucker

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): July 28 1944

8. AGE: Years: — Months: 6 Days: — If less than one day: ... hrs. ... min.

9. Birthplace: Salisbury Md
(Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER
12. Name: Carlton Tucker
13. Birthplace: Salisbury Md

MOTHER
14. Maiden name: Ana M Wilson
15. Birthplace: Va.

16. Informant: Jeanette Allen

Address: Princess Anne Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24-45 (month) (day) (year)

Cemetery or crematory: Parkside

Location: Salisbury Md

18. Funeral director: James F. Stewart

Address: Salisbury Md

19. 2/24/45 (Date rec'd by registrar) 1945 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 21 1945, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw ... alive on ... 19...

	DURATION
Immediate cause of death:	
acute Bronchitis	12 hrs.
Due to: pneumonia.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically. No

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J A Reclamation MD
Deputy Medical Examiner.
M. D. or other

Address: Salisbury, Md Date signed: 2/24/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

022(11)

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 1 mo. 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Vaughan. Infant boy

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	S.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 25, 1945.

8. AGE: Years | Months | Days | If less than one day: 17 hrs. min.

9. Birthplace: Salisbury, Wicomico, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER 12. Name: Ernest A. Vaughn

13. Birthplace: Grass City, Mich.

MOTHER 14. Maiden name: Alice E. Lick

15. Birthplace: Machipongo, Va.

16. Informant: Ernest A. Vaughn,

Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45. (month) (day) (year)

Cemetery or crematory: Parsons

Location: Salisbury, Md.

18. Funeral director: De Hill & Johnson Co.

Address: Salisbury, Md.

19. 2/27/45. Harriet E. Johnson (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 26 1945, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 25 1945, to Feb 26 1945 and that I last saw h.. alive on 2-26 1945

Immediate cause of death	DURATION
Premature birth	
5 months	
Due to	
Due to Prolapse of foetal membranes.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Prolapse of membranes up

23. SIGNATURE: M. D. or other

Address: Salisbury, Md. Date signed 2/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02201

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 years
Hospital, institution, or street address where death occurred: 107 Virginia Ave.
How long in hospital or institution? V

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 107 Virginia Ave
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: Claude N. Walker

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie M. Walker
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Jan. 22, 1892.

8. AGE: Years	Months	Days	If less than one day
53	0	10	...hrs. ...min.

9. Birthplace: Maddela Springs, Wicomico, Md.
(Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business: V

FATHER
12. Name: Alva N. Walker
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Mary L. Wilson
15. Birthplace: Wicomico Co. Md.

16. Informant: J. Russell Hopkins
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/45. (month) (day) (year)
Cemetery or crematory: Maddela
Location: Maddela Springs, Md
18. Funeral director: The Wills Johnson Co.
Address: Salisbury, Md.

19. 2/14/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1945, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9 1945 to Feb 12 1945 and that I last saw him alive on Feb 12 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Until death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

J. A. Cadmus MD

23. SIGNATURE: M. D. or other
Address: Salisbury, Md. Date signed 2/12/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-d

02202

CERTIFICATE OF DEATH

Reg. Dist. No. H 336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R.F.D.#1
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Delmar Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 405 Pine
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Garfield Columbus West

3. (b) Social Security Number: 716-03-1692

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Ryda West
6(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): August 23, 1883

8. AGE: Years	Months	Days	If less than one day
61	5	14	hrs. min.

9. Birthplace: Snow Hill, Maryland (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: Pennsylvania Railroad

FATHER
12. Name: Burton West
13. Birthplace: Snow Hill, Maryland

MOTHER
14. Maiden name: Hettie Ann Ruark
15. Birthplace: Salisbury, Maryland

16. Informant: Mrs Ryda West
Address: 405 Pine Street, Delmar, Del.

17. Burial (Burial, cremation, or removal): Date thereof: Feb. 10-45 (month) (day) (year)
Cemetery or crematory: Old School Baptist
Location: Snow Hill, Maryland

18. Funeral director: W. S. Mansel Co
Address: Delmar, Delaware

19. Feb. 9. 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7th 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiners Certificate, and that I last saw h alive on 19

Immediate cause of death: Fracture of Skull — DURATION: sudden
Due to: Struck by train
Due to: Collision of automobile and train
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Feb 7 1945
Where did injury occur? Delmar R.F.D. Wicomico Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Railroad crossing
Means of injury: Struck by train Injured at work? No.

23. SIGNATURE: Chas. T. Fletcher, M.D. or other
Address: Salisbury Md. Date signed: 2/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02203

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Worcester

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life / Md

Hospital, institution, or street address where death occurred: Pine Bluff Sanitorium

How long in hospital or institution? 7 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Bishop

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME Calvin Ray Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 26, 1918

8. AGE:

Years	Months	Days	If less than one day
26	1	20	..... hrs. ..... min.

9. Birthplace: Campbelltown (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: "

FATHER 12. Name: Thomas Williams

13. Birthplace: Md.

MOTHER 14. Maiden name: Ella Murray

15. Birthplace: Md.

16. Informant: Milton Williams

Address: Bishop, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1945 (month) (day) (year)

Cemetery or crematory: Powell Cemetery

Location: W. Salisbury, Md.

18. Funeral director: M. Tasker Watson

Address: Hebbardsville, Md.

19. 2/18/45 (Date rec'd by registrar) 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 1945 at 6.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/26/44 19.. to 2/15/45 19.. and that I last saw him alive on 2/15/45 19..

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	2 1/2 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Paul Eaton M.D.

M. D. or other

Address: Salisbury Md. Date signed 2/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-8)

02204

CERTIFICATE OF DEATH

Reg. Diat. No. 323

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 months
Hospital, Institution, or street address where death occurred: 415 Dana St.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron (If outside city or town limits, write RURAL and give nearest town)
Street No.: Walnut St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Samuel J. Williams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of ~~husband~~ or wife: Annie Williams
6.(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): March 10, 1871

8. AGE: Years: 73 | Months: 11 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: Nassawango, Worcester Md. (Town, county, and state)
10. Usual occupation: Farming
11. Industry or business:

FATHER
12. Name: Thomas Williams
13. Birthplace: Nassawango, Md.

MOTHER
14. Maiden name: Caroline Madkot
15. Birthplace: Nassawango Md.

16. Informant: Richard Williams
Address: Laurel Del. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/15/45 (month) (day) (year)
Cemetery or crematory: Hebron Cem.
Location: Hebron Md.
16. Funeral director: Mrs. C. Maguire Davis
Address: Hebron Md.

19. 2/15/45 (Date rec'd by registrar) 19 45 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 13, 1945, at 4:40 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 1944, to Feb 13 1945 and that I last saw h alive on 2-13-45 1945

Immediate cause of death	DURATION
Valvular heart disease	1 year
Due to: Nephritis	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles N. Brewington M.D. M. D. or other
Address: Salisbury Md. Date signed 2/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56-6)

02205

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 1

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Portia Viola Wright

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	aa	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): About 1899

8. AGE: Years: 45 | Months: | Days: | If less than one day: hrs. ____ min.

9. Birthplace: Eden, Somerset Co. Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: Hotel or Restaurant

FATHER — 12. Name: Howard J. Wright

FATHER — 13. Birthplace: Eden, Maryland

MOTHER — 14. Maiden name: Angeline V. Collins

MOTHER — 15. Birthplace: Snow Hill, Maryland

16. Informant: Mrs Kinley Wright

Address: Princess Anne, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 7-1946 (month) (day) (year)

Cemetery or crematory: Friendly

Location: Near Edgar md

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md.

19. 2/7/46 (Date rec'd by registrar) 1946 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1946, at 7:30 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__

and that I last saw h__ alive on ____ 19__

Immediate cause of death	DURATION
Cardiac Failure	2 hrs
Due to	
Due to	
Other conditions: Uterine Fibroid	yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Uterine Fibroid

Date of op. 2

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: J. M. Ward M. D. or other

Address: Salisbury Date signed 2/8/1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9450)

CERTIFICATE OF DEATH

02206

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Gov Road, R.D. 3.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: Richard Wyler

3.(b) Social Security Number: 083-03-1141

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Magdalen Wyler
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): April 6, 1897.

8. AGE: Years: 47 | Months: 10 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Paquville, Tuscarawas, Ohio.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER
12. Name: William Henry Wyler
13. Birthplace: Ohio

MOTHER
14. Maiden name: Emma Sarah Lahrman
15. Birthplace: Ohio

16. Informant: Mrs. R. H. Wyler
Address: Salisbury, Md. R.D.3.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: 2/24/45 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Washington, D.C.

18. Funeral director: The Hill Mortuary Co.
Address: Salisbury, Md.

19. 2/26/45 (Date rec'd by registrar) 1945 — Harriet L. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22, 1945, at 8 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 17 1945, to Feb 22 1945
and that I last saw h. alive on Feb 22 1945

Immediate cause of death	DURATION
Rupture of Mesenteric Blood Vessel & Coronary Thrombosis	Min.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Ruptured Mesenteric Blood Vessel
Date of op. 2/17/45
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: / Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 2/24/45